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RADIUM VERSUS OPERATIONS IN THE TREATMENT OF MALIGNANT DISEASE.

BY

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I. *Introduction*.—In opening this discussion my object is to bring before the profession (*a*) the prevalence of certain common forms of malignant disease in this province, (*b*) the practical results of the use of radium in malignant disease. and, (*c*) the conclusion that radium cannot abolish surgery and that good results can be obtained only by a combination of surgery with radium and by deep X ray therapy. Radium workers should be very conscientious surgeons, and the co-operation of a group of conscientious radiologists is essential; the surgeon and the radiologist should work together and assist each other to ensure the safety and comfort of the patient and to achieve better end results.

II. *Incidence of Malignant Diseases as estimated by the cases treated in the Madras General Hospital.*—No discussion on a subject like this can be complete unless the incidence of malignant disease is surveyed. The present survey is based on the records of the General Hospital, Madras.

The figures given below also show that the attendance of cases of malignant disease at this hospital has not increased during the past nine years, during which radium treatment has been introduced.

The following table shows the distribution of the cases treated with radium (860) during the period 10-4-35 to 17-12-37.

	Males.	Females.
Epithelioma cheek	303	48
„ jaw	25	4
„ cheek and jaw	9	2 (Lower)

	Males.	Females.
Sarcoma cheek	1	
Leukoplakia cheek	1	
Epithelioma cheek and gums	1	
„ cheek and palate	2	
„ cheek and angle of mouth	1	
„ angle of mouth	1	
„ cheek, lip and palate	1	
„ gums	1	
„ cheek and lip	5	
„ lip	37	1
„ tongue	97	10
Leukoplakia tongue		1
Epithelioma of :—		
Floor of mouth	8	1
Palate	24	2
Tongue and cheek	1	
Tongue and floor of mouth	1	
Cheek and floor of mouth	1	
Fauces	2	
Tonsil	11	
	1 (recurrent)	
Tonsil and tongue	2	
Sarcoma tonsil	3	
For glands neck secondary to oral epithelioma	13	1
Submaxillary gland tumour	1	
Sarcoma Nose	1	
Rhino sarcoma	7	
Epithelioma :—		
Larynx	14	
Maxilla	2	
Antrum	8	
	1 (recurrent)	
Nose Epithelioma	7	
Post cricoid growth	3	
Oropharynx	1	
Nasopharynx	6	1
Pharynx	3	
Polypus nose	2	
Epithelioma Mastoid	2	
Nasopharyngeal fibroma	1	
Tumour Ethmoid	1	
Inferior Turbinate	1	
Nostril	8	

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	Males.	Females.
Glioma & Orbital tumours	5	
Parotid tumours	6	1
Epithelioma of:—		
Oesophagus	4	
Stomach	1	
Rectum	4	2
Ano-rectal junction		1
Anus	1	
Breast	1	34
do recurrent		2
Vagina		2
Vulva		1
Adeno-carcinoma penis	1	
Penis	23	
do recurrent	2	
Secondary glands groin	6	1
Scrotum	2	
Malignant Thyroid	1	1
Rodent Ulcer	15	6
Epithelioma skin-leg	1	2
Malignant tumour	2	
Scalp	2	1
Face	1	
Groin	1	
Melanoma foot	1	
Lymphosarcoma neck	8	2
,, axilla	1	
Sarcoma abdomen	3	
,, arm	1	
,, thigh	1	
,, skull	1	
,, femur		1
,, back	1	
Tumour abdominal wall	1	
Recurrent fibroid ; abdominal wall	1	
Endothelioma abdominal wall	1	
Giant celled tumour bone	4	1
Growth neck	2	
Sarcoma chest wall	1	
Sarcoma scalp	1	

The comparatively low number of female patients who have been treated for malignant disease in the above list is probably due to the following facts .—

1. There are two separate hospitals for women where alone cases of the carcinoma of the cervix are looked after.

2. The number of beds available for women in the Government General Hospital is less than a third of the total number of beds.

3. The attendance of women at out-patients is less than half that of men.

4. The average in-patient attendance of women is one-third the attendance of men. It is to be noted that oral carcinomata form a substantial majority in this province. Out of the 860 cases referred to above 623 *i.e.*, 72 *per cent* were oral carcinomata; 553 were males and 70 females.

III. *Some General Considerations for Radium Therapy and for Surgery in the Treatment of Malignant Growths.*—This is the only province in India where radium is available for the poor in three centres. The Government has 1.5 grammes at present in Madras. And as Radon is now being used here and will also be available in the moffusil centres in future one may review the cases for future guidance.

Even the poor and the ignorant know about the value of radium as a remedy, and its availability in Madras brings to the city hospitals a large number of advanced cases for which nothing can be done. This knowledge has not succeeded in bringing the early cases to the hospitals. It has not mobilised the members of the profession either to the detection of the early cases or to an urgent sense of early diagnosis or to a systematic campaign for the recognition and treatment of pre-cancerous lesions. Neither has it led to a true appreciation of the indications for the use of radium amongst the members of the profession in administrative charge of moffussil hospitals. Advanced cases, cases with obvious metastases, are still being sent to Madras at public expense with recommendations.

Spencer and Cade (1931) write:—

" The lay public and a number of medical men are still under complete misapprehension as regards the practical possibilities of radium therapy. Its possibilities are exaggerated, its pitfalls are underestimated and the medical literature as well as the lay press offer constant examples of unreasonable claims and unjustifiable statements. It is however as cruel and misleading to deprecate as to exaggerate the usefullness of this very delicate weapon, which in careful hands, controlled by minds or unbiassed or unprejudiced cures a " selected " few, relieves a great many and robs us of one of the benefits of excisional surgery ".

Pure surgery is the only treatment for

1. Carcinoma of the stomach, caecum, colon and rectum,
2. Growths of kidney, ureter, and
3. Some cases of growths of bladder.

Coagulation diathermy is the treatment useful for Growths of bladder.

Radium treatment:—(a) It is effective for primary conditions of

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1. Carcinoma of the lip. 2. Epithelioma of the anus. 3. Tongue, and cheek. 4. Carcinoma of the cervix uteri. 5. Rodent ulcer, if it has not involved the cartilage or the mucous membrane.

(b) Radium is of some use in rendering an inoperable condition, operable, occasionally in breast cases ;

(c) It is used for alleviating the condition in inoperable cases, as advanced carcinoma of breast, oesophagus, larynx, antrum, nasopharyngeal growths, tonsils, palate, cervix uteri.

It is not possible to give a follow-up from this hospital. One's experience is gathered from individual cases under one's observation and reports from their medical attendants.

It is fair to state that biopsy is not done now for diagnosis except very rarely ; no grading of the growth (*Broder's* classification) is attempted and the following views depend on clinical experience. *Bomb* therapy isnot done at present here.

IV. *Radium and surgery in the treatment of Malignant Growths of the various regions of the body* :—

(A) Carcinoma and other malignant growths in the region of the mouth.

The incidence of oral carcinoma has already been referred to. When it is realised that these 623 cases involve the cheek, the tongue, the lips etc.—parts which are looked at so frequently either by oneself in the mirror, or by the other members of the household or by the friends, parts which even in the earlier stages of the disease interfere with the ordinary cleansing of the mouth, with drinking and eating—it is very surprising that they do not come for treatment in the early stages.

1. *Malignant growths of the tongue and cheek.* Operative treatment has been entirely abandoned for the primary lesions of lips, cheeks and the anterior part of the tongue and floor of the mouth. Interstitial radiation under an anaesthetic with the preliminary removal of septic teeth two weeks before radiation are practised. Surface application, by moulds over the tongue and cheek, can be tried effectively in cases where the patient is not suitable for an anaesthetic, provided, (*a*) the patient can open his mouth well, and (*b*) the radium is available for a fortnight.

There is some difficulty in diagnosing the cases of the posterior third of the tongue ; they come with dysphagia and an examination under an anæsthetic and the co-operation of a throat surgeon are very helpful. They react well to radium but a mould is not suitable ; the growth should be made accessible for radium implantation by splitting the cheek ; I did not find

retrograde needling from the neck effective. Cases of carcinoma of cheek, which have invaded the gums, the jaw, angle of mouth and lip and floor of mouth do not react so well and the prognosis is definitely poor, when the floor of the mouth is involved.

When the growth degenerates and forms a number of fistulous communications with the exterior and when the masseter muscles get infiltrated, there is difficulty in opening the mouth. To this is added, the sepsis, resulting from neglect of oral hygiene. These classes of sufferers are not obviously suitable for any radium treatment or surgery.

Cases treated with radium must be examined in three to four weeks' time and suitable treatment of the lymphatic areas of the neck must be given. A radium pad for the lymphatic area when there are no palpable glands and a block dissection when glands are palpable must be done. There is no doubt that cases whose lymphatic areas have been dealt with live much longer than the cases whose lymphatic areas have not been dealt with by operation or by radiation with deep X-ray or radium. It is here that the conscientious surgeon and the radium worker and the practitioner should co-operate. The practitioner knows that careful palpation without hurry, by relaxing the structures, is essential to detect lymphatic gland enlargement. Patients are often correct when they complain of a pulling sensation or a cord like feel under the lower jaw and in the neck. It is the metastases and not the primary disease that usually cause the death of the patient. It is here that I want to sound the warning note, that the indiscriminate use of Radon may not after all be useful or enhance the end-result. Surgical diathermy is useful if the jaw is affected and the resulting necrosed bone may subsequently be removed. Excision of the lower jaw, has become a very uncommon operation now-a-days, but in suitable cases the end result will be better. There is still an indication in some of these cases to excise the lower jaw.

The tongue cases require careful watching. Primarily, radium for the tongue and a radium collar for the neck is given. We must take out the glands before they are infected. If the glands are clinically invaded, there is no use taking them out. Theoretically a double block dissection is required. I have noticed that in two of my block dissection cases, two years afterwards, the patients came back, with enlarged glands in the opposite side of the neck.

Gland dissection by itself is a first class operation and there is no use in half-hearted operations. The operative mortality in this hospital, after this operation is very low. Primary growths disappear and a mobile tongue results Recurrences are common after a year. A second dose of radium should not be given earlier than three months; it is important to be able to diagnose a radium reaction from a recurrence.

2. *Epithelioma of the palate* is treated by radium mould or by burning them with diathermy cautery; the cervical glands (upper deep

cervical region) must be treated with radium collar. These cases are unsatisfactory and they depend upon the type of malignancy. There is a case of an elderly man of seventy with adamantanoma of the upper jaw; alive for eight years. These are obviously rare. Majority of the palate cases do badly and no excision of the jaw is practised at present in this hospital.

3. *Epithelioma of the lip.*—Some of these cases are seen early but some in a very advanced stage. They are of low grade malignancy and even the advanced cases react well to radium. The lymph glands must be removed by a block dissection and in most cases, a bilateral removal of at least sub-mental group and submaxillary group is essential.

Bloodgood says " my experience of radium in early cancer of the tongue is the same as with cancer of the lip; it cannot compete with good surgery. Many early operable cases are made inoperable by the use of radium. There can be no question, concerning the value of the use of radium in the treatment of malignancy of the tongue, under certain conditions, but clearly operable cases should not be treated with radium."

4. *Epithelioma of the floor of the mouth.*— may appear primarily on the floor of the mouth or secondary to epithelioma of the tongue. Prognosis is bad and these cases do not react to radium. Pure surgery has been followed by high mortality and is not practised here at present.

5. *Uvula.*—If the growth is confined to uvula it is better excised; and double Block dissection is required. Prognosis is not good. Radium in early stages is good, but in late cases it is definitely bad. It is difficult to retain radium by interstitial method here.

6. *Upper jaw.*—Excision of the superior maxilla was a routine operation with 40% mortality, ten years ago. Radiation by interstitial method with or without a surgical exposure, embedding radon seed in the growth and/or deep X-ray are practised. Cases come only in the advanced stage. Most hospital cases die in a year and there was one case where after radium treatment, the patient lived for two years. It is wise to operate after radium treatment, if the disease is confined to the bone, followed by a block dissection. If the disease has spread beyond the limits of the bone into the cheek, or backwards into the spheno-maxillary fissure, complete excision is not possible and should not be attempted. In a case, recently, in a young man, after radium the growth of the jaw disappeared, the glands in the neck faded away, only to be followed by a metastases in several parts of the body. Radium needles are dangerous weapons, if used with insufficient skill; there is no doubt that it stimulates a malignant growth of a certain type; there is no doubt in the statement that metastases appear as a result of radium treatment, in far away parts of the body.

7. *Tonsils.*

(*a*) Sarcoma of the tonsils melt with radium.

(*b*) In carcinoma of the tonsils, a block dissection with pre-operative radiation with X-rays is always to be done. The effect of radium is most disappointing in carcinoma.

8. *Sub-maxillary growths.*—are rare. A case treated by excision with post-operative radiation is alive after 8 years; he has had two further radiations, for local recurrence 5 and 3 years ago. He is rapidly declining in health.

B. *Malignant Disease of the Pharynx*—Malignant disease of the pharynx is fairly common. They all come in a very advanced stage and the utmost that has been possible to do, is to apply a radium pad externally. It has not been possible to get early cases for operation. A carefully planned operation in suitable early cases, will give good results.

C. *Extensive carcinoma of the larynx.*—is very commonly seen, in advanced stages here. The number shown in the list, is no guide to its true prevalence. Many advanced cases could not be admitted. It is not possible to do anything for them when they come so late. It is well to realise, that if operation is carried out, when the growth is confined to the vocal cord, the prospect of ultimate cure is better than that for carcinoma in other parts of the body. Obviously early detection is of great importance.

D. *Malignant Tumours of the nose.* Radium and deep X-rays are almost always used now.

E. *Parotid growths* must be treated by removal as they are all potentially malignant. A malignant growth is treated by radium first and can be excised six weeks later. Operation itself has been followed by a large percentage of recurrences.

F. *Carcinoma of the oesophagus* is a baffling problem. Excision has not been attempted so far here. In view of the misery and suffering, which is witnessed, I am convinced that gastrostomy must be done as early as possible; this will give them a comfortable life for 18 to 24 months; their lives are made miserable by local sepsis, and extension into peri-œsophageal tissues, involvement of pleura, bronchi and mediastinum. This can be minimised or postponed by early gastrostomy. Gastrostomy in the hospital type of advanced cases has 40% mortality and is hence unpopular with the surgeon and the staff. Deep X-ray therapy and intra cavitary radium are the usual routine.

G. *Carcinoma of the rectum.* While radium is the most effective method of treatment for carcinoma of the anal region, radium is not of any value in rectal growths. Intracavitary methods, interstitial method of application in the post-rectal space, intra-peritoneal interstitial methods have been used and they are of no value in my experience. Radium must not be used

without a colostomy ; the plight of such a patient who has had radium without colostomy is very miserable ; colostomy followed by a standard operation is the ideal method. Colostomy alone, will give a lease of life for three years and it is well managed. The profession must dispel the idea that a colostomy is inconsistent with an active life.

H. *Breast.* Before discussing the treatment of Breast carcinoma, one may as well remind oneself, that ten years of radium treatment in this province *i e.* treatment by non-removal of breast, has not in any way brought early cases to the doctor. The early cases are those that come with mastitic breasts and one has to make up his mind in the treatment of these cases. Sir Anthony Bowlby used to point out that the natural period of existence without any treatment is three years for these cases. One has to consider how much more can be gained by the operation or radium or both combined, in the lease of life.

The *clinical course* of the breast carcinoma can roughly be divided into four periods.

(*a*) the first period of 7 to 9 months, when nothing is palpable except only a lump with no superficial or deep attachments and no glands.

(*b*) the second period of 9 months with deep or superficial attachments : but there is no extension outside and there is no ulceration.

(*c*) the third period of nine months with enlarged glands, and later ulceration and fungation is present.

(*d*) the fourth period, when skeletal metastases are seen.

Treatment. With the best operative technique by the best surgeon, only less than half the patients will be free from any signs of the disease at the end of 5 years, even when the growth is in its earliest stages, apparently confined to the breast itself and when no evidence of invasion of glands can be detected, on the most careful microscopical examination

Mr. Keynes of St. Bartholomew Hospital, London, advocates radium alone, as the method of treatment reserving local excision for any remnants of tumours or for local excision of breast. Mr. Keynes has produced figures in support of this opinion. I have seen his cases demonstrated and they are really good results. I consider that his cases are really very early ones as compared with our cases here. Not only his cases but all the cases that I have seen in various London hospitals are really early cases compared with ours.

Mr. Keynes' colleagues, all still practise the Halstead operation in the same hospital and it is difficult to understand why they are not convinced of his views It is true that there is a definite operative mortality and risk in this country nearing 5 to 10% in the Halstead operation. 10 cases were

operated in 1935 and 16 in 1936 while 36 had radium treatment. Two cases who have been under prolonged observation are cases who have been operated (Halstead's method) and who have had post-operative radiation by surface application, of radium or deep X-ray therapy repeatedly. The treatment of choice for early cases is by operation (Halstead). In other cases Radium treatment is good. Radium treatment may be followed by local excision of the tumour mass or breast. Radium treatment does not prevent metastases in the glands or distant metastases or into the opposite axilla and breast. One has noticed large number of nodules on skin after interstitial treatment and this cannot be a coincidence In what type of cases exactly this will occur it is impossible to say. Cases of duct papilloma, duct carcinoma all must be operated.

If the neuro-vascular bundle in the axilla is affected it is not worthwhile operating and you should not treat the axilla in these cases with radium. Deep X-ray is useful to get rid of skin nodules. The technique of Radium therapy is that advocated by Mr Keynes. Do not push the needles into the tumour. You may disseminate

In atrophic schirrhus of breast, radium and operation are not to be advocated They live 5 to 10 years without operation. If you interfere, you will get widespread dissemination. Deep X-ray may be used.

The following are contra-indications for operation. 1. Widespread extension of the growth. 2 Presence of secondary skin nodules. 3. Wide ulceration or oedema of skin 4. Enlargement of supra-clavicular glands 5. Presence of distant metastasis. 6. Involvement of both breasts. and 7. Enlarged fixed glands in the axilla.

Method of dealing with doubtful lumps.—There are occasionally difficult cases ; a case of tuberculous adenitis, of the pectoral group, was met with in an elderly lady ; a growth was mistaken for an abscess in a young woman ; local excision and aspiration with a needle on the operation table are not to be despised in doubtful cases.

The above remarks on carcinoma of the female breast, apply also to the cases of carcinoma of the male breast. These also come in advanced stages.

I. *Epithelioma of the Genitalia* :

1. *Penis* When surgeons in western countries advocate radium for these cases th y probably see the case, with less than a shilling-size ulcer. Here, we see huge cauliflower like growths, ulcerative types, which definitely have invaded the body of the penis. Experience in three cases with radium does not encourage me to advocate this treatment at all. Extirpation of the penis with removal of lymph glands easily gives a freedom from trouble for 7 to 15 years and operation has to be advocated as a routine.

2. *Prostate.* The prostates removed must be examined microscopically and if found histologically malignant, they must be treated with deep X-rays.

The type of prostate, which is clinically diagnosed malignant runs its own course without being affected by deep X-ray. In one case of a young man. interstitial radiation did not mitigate the agony of the disease which pursued a rapid course.

3. *Vulval and vaginal growths* are better operated. Limited experience of two cases showed extensive infiltration after radium.

J. *Growths of the Urinary Tract.*

1. Growths of the kidney and ureter are dealt with successfully by operation. May I stress, that every case of haematuria, must be sent to the surgeon for a thorough investigation at once.

2. Growths of the bladder do not respond to radium. Surgical diathermy was useful in one case for 2 years. In spite of the dysuria, most Indian patients have arrived in this hospital at a late stage.

K. *Malignant Growths of the skin.*

1. *Rodent ulcer.*—There is no doubt that unscreened radium or interstitial radium acts well on a large percentage of these cases ; it leaves a supple area and the cosmetic result is good. Although it occurs in other situations, the common situation being face, it is no doubt desirable to get a good cosmetic result.

Here again a radium worker who may not have the opportunity to see the bad cases, or the surgeon who does not see his recurrent cases may draw fallacious conclusions regarding the efficacy of treating these cases, with radium alone.

I have a case who first saw me in 1930, who is in a terrible plight now ; he has had three radium treatments. There is a lady, who has been under treatment for 8 years. Half her nose is destroyed, and the disease is not arrested.

In Guy's hospital, London, the results of operation alone, in a large number of cases, for the past ten years, has been quite superior to Radium alone.

The following rules of practice may be laid down Size of two anna silver-bit can be cured by anything as CO_2, Radium, X ray, diathermy excision, surgical diathermy.

Up to the size of half a rupee wide excision if possible must be done.

If mucous surface is involved, radium is of no use; the ulcer will go on spreading. It requires wide excision, flat diathermy application is best; there will be necrosis of bone which will separate later. The scar is supple and the ulcer heals rapidly.

In the case of Ear, in one case, the *Pinna* had to be excised. In spite of the deformity, this is better done, as the bone or the dura or both may become involved and the ulcer may spread into the meatus.

Radium burns may occur in small or large cases. The majority of radium burns become epithelioma. Rodent ulcer and epithelioma round about the eye treated by any method except excision has led to conjunctivitis and even panophthalmitis; an operation would have been better. Excision and skin grafting have to be done. This cannot be done without excising the eye. If the rodent ulcer involves the muco-cutaneous junction, it is difficult to eradicate it.

2. *Skin Epithelioma*—is better treated by wide excision and skin grafting. When the bone is invaded amputation is the treatment of choice. Dissection of glands must be done after 2 weeks.

3. *Melanomata.*—are better treated by wide excision: the other methods of treatment by caustics, CO_2, diathermy, ligatures and partial excisions are to be condemned.

Conclusions.

(1) Oral cancer predominates in this hospital where patients come from all parts of the province.

(2) A central organisation for each province to educate the profession on the *early* diagnosis of malignant disease is essential.

(3) Radium is no panacea for malignant disease; it has to be used intelligently and conscientiously as regards (*a*) the application (*b*) correct spacing, (*c*) uniform linear intensity and (*d*) the correct period of application.

(4) All surgical measures must be adopted for the treatment of the lymphatic area.

I thank Lt.-Col. Cruickshank the Superintendent of the Government General Hospital for the permission to publish this paper.

XIVTH ALL-INDIA MEDICAL CONFERENCE.

PRESIDENTIAL ADDRESS.

Since we met last year, great changes have taken place in this Country of ours, a bloodless revolution has come about; the Congress the predominant political party has withdrawn its opposition and taken up the reins of Government in 7 out of the 11 provinces; and who can say, that the ideal to which Congress is wedded, and for which its members are pledged to work, is not silently but effectively influencing the activities of the remaining four provinces ?—And what is that ideal ? The ideal is "Service" to the dumb, down-trodden, oppressed, afflicted masses. And what should be the attitude of the medical profession to this "ideal"? Can the members of a noble profession, whose lives are dedicated to the service of suffering humanity, and whose governing ideal has been and continues to be "going about doing good,' remain passive during this revolution ? If the Congress Ministries are to justify their existence, they have to devise a scheme for the medical relief of the masses, they have to plan out an intensive campaign to dispel ignorance and superstition and to develop an intensive health consciousness of the people, which alone can effectively check the inroads of epidemic diseases and the immense mortality rate due to them; they have to *break down the barriers of entrenched service interests*, and bring the profession in direct touch with the masses and their needs; they have to consider whether it is yet justifiable to spend public funds, in order that enlightened self-interest of the Services may be protected, and whether, while using the funds contributed by the people, they are entitled to tell them that "charity" is being doled out to them, out of these contributions, by establishing public hospitals and by appointing public servants. In the constructive efforts referred to above, how can we, members of the Association, individually and collectively help in bringing medical relief to the masses in the villages and improve the sanitary conditions in which they live, both of which are admittedly grossly inadequate. I do not forget that medical practitioners also have to exist and cannot live on charity and also deal out charity But I do plead that even in our own interests, it is essential that, as early as possible, the masses should be protected from the ravages of the preventable diseases, so that the economic position of the Country as a whole is bettered. It is a well-known truism that ignorance leads to poverty, poverty brings on diseases and that these three factors act and react on one another, and thereby ruin millions. After all, people do not live their lives in watertight compartments. All the defects and disabilities of the people are to be handled together, all communities and classes should join in the struggle. Whatever I shall have to say to-day will be from this point of view.

Before I take up, however, the bigger issue, let me take a rapid survey of the important subjects which have, from time to time, engaged the attention of successive Conferences and of the Indian Medical Association in the recent past.

Indian Medical Council

This Council was admittedly formed to establish "Efficiency at home and honour abroad." By the very preamble of the Act, the activity of the Council was limited to ensure "efficiency" only of the Medical Colleges of India where five thousand students pursue their studies. The Indian Medical Council has, however, no power to influence the ethical standards of the 500 graduates which pass out of the Colleges each year, because it possesses no Register and has no power to admit or erase any names from the Provincial Registers. The scope of usefulness of the All India Council has, therefore, been narrowed down And why? It is suggested that the Government could not solve the riddle of keeping an All-India Register and yet keep the Licentiates out of it, both of which they were anxious to do. Why must they keep out the Licentiates? There are 28 medical schools in India, with 5,000 students, which turn out 1,000 Licentiates every year. Are the Government not anxious to maintain an uniform standard of education of the Licentiates? Why do they fight shy of letting the Indian Medical Council look after the standard of their education as well? The Licentiates themselves are anxious to raise the standard of teaching in the schools, the parents are ready to get their boys 5 years' training in them, but the Government persist in keeping separate the two classes, the Graduates and Licentiates. The Government employ 1,750 Graduates and 6,500 Licentiates. Obviously they consider the former as superior and entitled to a higher salary than the latter. Is it merely the financial aspect of the problem that compels the Government to keep two standards of education and two types of doctors? Do the Government realise that by doing so they sacrifice "efficiency" to "economy"? But by being so parsimonious, do they not jeopardise the interests of the masses, by leaving them in medical charge of licentiates who admittedly possess a lower standard of efficiency? Do they not realise that all the licentiates that pass out are not employed by them, that the people of this country desire to get the best scientific medical service; that a large number of licentiates who now practise with efficiency and dignity in different parts of the country, desire to raise the standard of their education, and that, as they too have self-respect, they are no longer content to work under the jurisdiction of some one else? Then why not raise the school standard? There are some fundamental propositions however, regarding medical education, which must be accepted by every medical institution whether it be a school or college. A candidate for admission must possess a sufficiently high standard of preliminary training in order that he may profit by the instruction given him. A minimum period must be spent in the study of the fundamental sciences, like Anatomy, Physiology and Pharmacology and then, a minimum period of clinical work is essential for obtaining insight into the nature of disease and mode of treatment. In the

schools, it may not be necessary, perhaps, to lay much stress on special subjects or departments as is done in the colleges, but a minimum period of instruction must be provided for the study of Fundamental Sciences and for clinical work. In my view, this period cannot be less than five years. A college or a school may make their own arrangements for selecting particular types of candidates for admission, having regard to their preliminary training and to their intellectual capacity Once it is conceded that every medical student must possess a suitable type of preliminary training and undergo a minimum period of study in a medical institution, there is no reason why the Indian Medical Council should not be put in charge of both types of institution and there is no reason why the Indian Medical Council should not possess an All India Register. I am glad to find that the Bill Drafting Sub-Committee of the 13th All India Medical Conference, appointed at Karachi, have suggested an amendment of the Act to include Licentiates. To my mind it should be made clear that these licentiates will in future obtain a 5 years' training after receiving a sound preliminary scientific training. I suggest also that the Act should be amended so as to include the creation of an All India Register.

So much for efficiency at home What about honour abroad ? The Medical Act says, "The Indian Medical Council may enter into negotiations with the authority in any State, outside British India, which is entrusted by the law of the State with the maintenance of a Register of medical practitioners, etc." In all cases of such approach by the Indian Medical Council, these countries must have found it curious that the Indian Medical Council maintains no register and wondered how was it possible for the States possessing a register to have a scheme of reciprocity with the Indian Medical Council "without" a register And the enquiries by the Indian Medical Council showed that most countries refused to deal directly with the Indian Medical Council, as they were satisfied with dealing with the General Medical Council in England, which is all that matters to them Here then is the "honour abroad" maintained ? And why should any country bother about the Medical Council of a country which does not possess the status of an Independent State ? The Indian Medical Council has not even the elementary power of protecting the interests of the Indian Medical profession by prohibiting or disallowing non nationals from practising in this Country.

MEDICAL EDUCATION

The next important subject that we have from time to time discussed in these Conferences is the question of medical education I have incidentally referred to it in my discourse on Indian Medical Council. We have stressed the necessity of having a suitably arranged pre-medical course in Biology, Chemistry, Physics, so that students after admission into a medical institution are able to take full advantage of the training they receive. All the world over, educationists have felt that with the growth of medical science, the type of instruction hitherto given to students should materially change. Everywhere it is agreed that of the five year course, two should be devoted to

Fundamental Sciences, three to clinical work, that subjects like Hygiene and Medical Jurisprudence, however important they be, should not be given any extra attention in the education of an average medical student, as they should form special subjects for experts, that applied Anatomy and Physiology, Pathology and Pharmacology should be continuously studied during the clinical period, that, in effect, all subjects of medical education should be organically linked together and not grouped in such water-tight compartments as to make the students feel that, as he progresses on in his studies, he should forget what he has learnt in one year before he goes on to the next

POST-GRADUATE STUDIES.

But I urge that even after he has satisfied the examiners in the final test, the graduates, under a recognised teacher, should have at least 6 months' course of post graduate studies, during which period he will be given the option to choose any special subject he is interested in. On receipt of a satisfactory report from the teacher concerned the graduate is admitted formally to the degree. It may be urged that there is not enough room for giving such post-graduate training to all who have passed the final test. Such argument, however, cannot be allowed to prevail in view of the necessity and desirability of giving post-graduate instruction to all persons on whom the responsibility for human lives would rest. Provision for such instructions, therefore, must be made.

MEDICAL TEACHERS.

But any scheme, however, perfect, will fail in producing effective results unless teachers are appointed who can really teach. I can say with all the emphasis I can command, that every person who possesses a degree—even a high degree—cannot be a teacher, that it takes years, even for a person of superior qualifications and intellect, to learn the art of teaching, that in medicine a man must have devotion and affection for his subject before he can properly teach it, that every medical teacher must have an aptitude for and experience of research before he can fully discharge his trust. But what do we find to-day? By the fiat of the Government it is decreed that members of a a certain Service must occupy certain important teaching posts in the Medical Colleges in India and that the Research Departments should always be under the control of members of that Service. I have no quarrel with individual members of the Service, nor do I grudge the prospects such fiat gives to them. Some amongst them, I am proud to say, have been my guide, friend and teacher. It is the system which I deplore. It is a tragedy that teaching appointments should be reserved for members of a Service which admittedly exist for two main purposes—namely, to serve as a War Reserve, and, secondly, to secure for Europeans in Government Services, medical help from members of their race. For a man in the service, continuity of work in a particular department or post cannot be ensured, and in the absence of such continuity, teaching, research, and even efficient treatment are bound to be defective. I will deal more fully with this subject presently. But it has been my

experience that as a result of such an arrangement one I.M.S. man successively served as Resident Surgeon, Resident Physician, Physiologist, Chemical Examiner to Government, Ophthalmologist, finally as a Consulting Physician ; he had to occupy different posts in the College, as he had to remain in Calcutta ; so the posts were made to suit him and not he the posts. And what about research ? Whether it be malaria transmission enquiry, cholera enquiry, whatever be the nature of research, the choice falls first on the European member of the Indian Medical Service. We deplore communal considerations affecting affairs of our daily life ; we deplore, thousand times more, that they should enter the sacred sphere of teaching and research.

INDIAN MEDICAL SERVICE

It is but a natural sequence that I should discuss this service next.

On numerous occasions, in public and in the press, in Conferences and Committees, members of this Association have commented on the mode of recruitment to this service, on the differential racial treatment meted out to the members of the Service particularly regarding salary and allowances, on the way in which they are allowed to usurp important teaching and research appointments ; in fact, the Association have often declared that this Service need not exist at all. Various branches of the Association, in different Provinces in India, have also urged on Provincial Governments, the need for a reorientation of the present policy of Government regarding the Services; the latest of such memoranda is the excellent one presented recently to the Minister-in charge of Local Self Government of Bombay. I will not repeat those arguments, convincing as they are, but merely discuss this question from the point of view of the masses of India who suffer patiently and pass on to the life beyond, silently and uncomplainingly.

We have in India to-day according to latest report available, 220 members of the Indian Medical Service transferred to the Civil Side. This transfer is justified financially because it is said to form a "war" reserve. This transfer is further justified on the ground that without this tempting prospect, the right type of medical men will not enter the Indian Medical Service One wonders how they get candidate for the R. A. M. C. to look after the European army in India who have no such prospect.

Out of the 220 posts, 166 are reserved for Europeans, because they are required to look after the European members of the Services in India. A large number of specialists', research and teaching posts are reserved for Europeans ' in order that specialists' attendance shall be available for European Government servants and families." On a rough calculation, the number of Europeans in the Services in India and their families, would not exceed 20,000 and for them we have 160 European I. M. S. officers with facilities for specialists' posts and overseas allowances and travelling allowances. Speaking about introduction of insurance provision against sickness for industrial workers, numbering millions in India, The Royal Commission on

Labour in their report of 1931 stated "There is a difficulty in that the industrial workers form only a small fraction of the population and it is difficult to justify any elaborate and expensive extension of State services for their exclusive benefit " I wonder what the Royal Commission will say to justify the expenditure of ovcr 20 lakhs a year and more for 20,000 Europeans. As I have indicated above, service conditions are always inimical to the making of proper teachers and research workers On the other hand, it is well recognised that the quality of service which a medical man can give to the patient, depends a great deal upon the personal relationship of the doctor to the patient. Liability to transfer is the usual rule in case of all services, according to the needs and exigencies of the services as a whole. Such frequent transfers of a medical man from post to post cannot, therefore, be in the interest of the people who might have developed a personal liking for him. Therefore, it is clear that the system of appointing a few men on high salaries and allowances, avowedly to satisfy the sentimental needs of a particular community cannot, in the interest of the suffering millions, be continued in India as she is not capable of affording the luxury of such highly paid services.

HOSPITAL & DISPENSARY SERVICE.

There are over 6,000 hospitals and dispensaries, either maintained by the State and statutory bodies or aided by them; a few are maintained by private agencies. 200 members of the Indian Medical Service, a few belonging to women's medical service, 1,750 belonging to the Assistant Surgeons' service and about 6,000 licentiates, work in these Hospitals. The smaller hospitals and dispensaries are generally maintained by district or local boards and they constitute more than 3/5th of the total number. It is calculated that, on the average, a small dispensary in a rural area is expected to serve 50,000 to 60,000 persons living in sparsely situated villages. The remaining 2,000 odd hospitals, mostly stituated in urban areas, have 72,000 beds in all and treat on the average, according to the official report, one million people annually. But we are unable to find any scheme behind this hospital system. In Britain to-day, hospitals work under a definite scheme which provides for general and special services to the community, prevents overlapping and affords opportunities for intensive research work. The hospitals in India though mainly maintained out of public funds are yet the close preserve of the services. The Civil Surgeon is in administrative charge of the district hospital with, say, 200 beds; he may also be the Superintendent of the school situated in that district for training doctors, nurses and compounders; he is in administrative charge of the branch dispensaries in the district covering hundreds of square miles; he is also the medical adviser of the higher Government Officers and their families; he is the official medico-legal expert of the district and has often to appear in courts to give evidence; and then he has to treat patients in the hospital and engage in private practice. Therefore, he must be a teacher, a research worker, a medical authority, an expert medico-legal adviser and administrator, all rolled into one. It is true that he gets a decent salary, but he would not be human if he did not demand a return commensurate with the huge responsibility

which he bears and the work which he has to do. He and his assistants have all the same human failing. The patient, a member of the public, puts more faith—and rightly so—in the service men, because they have the unique opportunity of gaining experience and practice in the healing art in these hospitals with the immense materials available therein. The private practitioners thus find it hard to compete with them. Hospitals are being multiplied to provide for the medical treatment of the poor. Any increase in their number, however, correspondently lessens the chances of private practitioners of earning sufficiently. It may be some compensation to the private practitioners if they get equal facilities in the hospitals with the service men, (if services are to be maintained), because in that case the private practitioners can compete with the service men on equal terms. Be it remembered, also these very practitioners now and in future, are called upon to look after the welfare of a much larger number of people than are treated in the hospitals to-day, as at no time can it be possible for the State to provide accommodation and treatment for the millions that suffer every year from diseases in this country. In order that these private practitioners can give efficient service to the people at large, it is essential that they should keep themselves up-to-date and for that purpose they should have opportunities of getting experience such as are only available in a hospital. Therefore, while the hospitals, have to be maintained to give free service to the poor, the opportunity to work in them should be open to all, both in the interest of the suffering public and the practitioners themselves.

What then should be the hospital system in India? Many of these institutions owe their inception to the generous instinct of private donors in whom the agony of suffering humanity has evoked a ready response But the bulk of the money spent on these hospitals still comes from the funds of the State or of statutory bodies. If that be so, it is wrong, to my mind, to regard or to designate these hospitals as "charity" institutions. The State or the statutory bodies are merely spending public money—money contributed by the people for their benefit and relief. Therefore, the services given by the hospital staff, and the treatment provided in these institutions cannot be regarded as charity work The staff of these institutions should not belong to any specially privileged or protected class but as many of the practitioners as can find a place there, should be allowed and encouraged to gain experience therein; every member of the staff must always consider himself as a servant of the people. These hospitals should be placed under the control of local Committees consisting of representatives of the people, of the Government and of the Statutory Bodies who are and might be contributing towards their upkeep. They should no longer be under the complete control of the department of the Government as heretofore. If this step be taken it should be possible, to a large extent, to create local efforts and enthusiasm to supplement the contribution of the Government or of the Statutory Bodies towards the upkeep of the hospitals. Experience teaches us that if such control be given to a properly constituted body, the members of that body rise to the occasion and take living interest in such activities. The memorandum of the Bombay Branch of the Indian

Medical Association, above referred to, gives the example of the Vadilal Sarabhai General Hospital at Ahmedabad or the County hospitals in England. I may also quote the instances of the Chittaranjan Seva Sadan and the Jadavpur Tuberculosis Hospital in Calcutta where these institutions, with suitable contributions from the Corporation or the State, are giving very effective and efficient service to the people. I dare say there are more of such instances in India. Therefore, it is safe to premise that power coupled with responsibility always evokes responsive activity on the part of those on whom the responsibility is placed. The institutions should be classified as General and Special. The General Hospitals should be properly equipped with nurses and efficient staff and should have a fairly large number of paying beds, so that these hospitals will ultimately be maintained more by contributions from the people, made directly to the Hospital, than indirectly through the State. The Special Hospitals on the other hand, should be provided with facilities for teaching students, for research and for treatment on special lines. No effort should be spared to make them efficient; and these institutions should also be the training ground for post-graduate work At present we have no arrangement for post-graduate training anywhere in India. The Research Department as I have stated above, is kept a close preserve for the benefit af the few; Teaching and Specialists' posts are likewise preserved Naturally, those Indian students who desire to pursue higher studies in Medicine and to improve their status and prospects in life have to go to foreign countries. There again, difficulties have arisen. In England, where the students might naturally expect sympathy and aid, they get none. The India Office do not give any help except to members of the Services, particularly those belonging to the I. M. S.; officials of the Indian House and the High Commissioner also give no effective aid, because they have no real power, although they display pomp and show. In numerous instances, to my knowledge, they could not give to the students even such help which any one of us individually could give by influencing and interesting the authorities of the Institution with which we were at one time associated. This fact was brought home to me very forcibly during my recent visit to Europe. Many students complained to me of the difficulty of joining any institution in England because of the indifference or unsympathetic attitude of the authorities of those institutions. Even in the institutions under the control of the London County Council, which is dominated at present by the Labour Party in England, the Indians fare no better. No one can marvel at the attitude of the authorities of such Institutions, much as we may deplore it. I found that there are in England, to-day, a large number of Indian practitioners settled in the country and carrying on a fairly lucrative practice. The success of the Indian practitioners, even when they possess ordinary qualifications, naturally reacts on the minds of Englishmen. If the Indians were to take higher degrees and then settle to work in England their success would be more marked. Naturally such success cannot be viewed with equanimity by those whose interests are affected. Incidentally, I may mention that the success of the Indian practitioners in England is a fit reply to the argument of those who always raise the

side issue in India, namely, that Europeans always desire to be treated by persons of their own race. Our boys, in their anxiety to get post-graduate training, resort to other countries of Europe or go to America. In Paris, Rome, Berlin, Munich and in Vienna we see a large number of Indian students taking post-graduate training. In Vienna, perhaps, we have a larger number of Indian students than in other places. Austrians, as a rule, have a warmer heart than the people of other countries and Vienna has numerous institutions where ample materials and efficient staff exist. We welcome the presence here, amongst us to-day, Professor Rudolf Demel, Professor of Surgery in Vienna and a well-known Surgeon in that city. He is a teacher himself and a large number of Indian students know him personally. He has travelled six thousand miles from home, to convey the sympathy of the University of Vienna to the cause of Indian Medical students. He has come to India also to obtain a first hand knowledge of the medical students in India and of the educational institutions here. I hope and trust that we, in India, would soon be able to develop the Institutions where efficient post-graduate training would be given so that, in future the students may not be forced to go to other countries to get such training.

PUBLIC HEALTH SERVICE

The Public Health Service in any country has to deal with all aspects of the problem affecting the health of the people. It generally initiates and carries out all manner of preventive work, *e.g.*, vaccination; it carries on propaganda and publicity work; it appoints medical officers to look after the health of the school children and give them health education. It is responsible for sanitary arrangements, mainly for rural areas where masses congregate during fair and festivals; it also gives expert advice to sanitary authorities in urban areas. This department has also to take cognisance of industrial hygiene and health condition of workers in the mines. It is responsible for the welfare of labour in factories. The health problems in connection with railways, shipping and air services are also within the orbit of its jurisdiction; it supervises the birth and death registration and the preparation of mortality statistics. In India, all these functions have to be performed by sanitary authorities, perhaps under less helpful conditions than those obtaining in other countries. It is admitted that elementary ideas of sanitation are lacking among the ignorant poor in this country and the development of national health services is still in its infancy. Illiteracy, want of proper educational facilities lead to ignorance. Ignorance makes people cling to encrusted habits. Age-long customs, however insanitary and unscientific they be, become irremovable; superstition and blind faith in them serve to petrify them. And further a bad habit which in a village is inocuous may become positively harmful, if persisted in, when the villager migrates to a town. During the last two decades, due to causes we need not enter into now, thousands of villagers are migrating to towns carrying with them insanitary habits and unhygienic customs. This adds to the difficulty of effective health service in India. If 6·8 millions of people die every year in India, it is safe to assume that

10 times that number actually suffer from diseases requiring treatment. In point of fact, however, the report of the Public Health Commissioner of India shows that while from fevers alone, a million people die annually, the actual number of sufferers, from fevers, like malaria, is many times more. Col. Sinton, Director of the Malaria Survey of India, in his recent report, states that " there seems to be little doubt that malaria is responsible for at least one million deaths each year. There is very considerable evidence to show that at least 100 millions of people suffer from malaria in British India, and even that is probably a moderate estimate. In addition to this, there is indirect morbidity, predisposed by this disease, which may be between 25 to 75 millions cases." Col. Sinton further states that there is some reason to believe that " not more than 1/10th of the persons suffering from malaria in India actually receive treatment at the hospitals and dispensaries." Major General Megaw, Director General, Indian Medical Service, on the basis of an inquiry made by him in 1933 states: " The number of persons who suffer every year from malaria in India is not less than 50 millions and may reach 100 millions in some years." These are staggering figures of two experts in this line. From the mortality table, we find that 2 lacs of people die every year from cholera and there is not the slightest doubt that 3 to 4 millions of people suffer from cholera each year. It is safe to estimate that one million persons suffer respectively from plague and small-pox every year. Dysentery and diarrhœa takes a toll of nearly 3 lacs of people every year and there is no doubt that 3 millions of people suffer from these diseases. It is estimated, and perhaps the estimate is a moderate one, that not less than 2 millions of people suffer from Tuberculosis in India to-day. I will not mention other diseases which cause death or from which people suffer. It would appear, therefore, that our problem is to find medical relief for 110 millions of people. By organising our public health departments, we can prevent the incidence of diseases, and the number of the sufferers will then fall correspondingly.

It seems to me that the best way to solve the problem is to organise the public health service in the following manner:

The service should be divided into Rural and Urban.

Rural Health Centres.

There should be a rural health centre in charge of an official of the Health Department. Each such centre should be in charge of an area of not more than 100 square miles on the average. In Bengal, at present, each such centre coincides with a thana area. It is a wrong method to mix up administrative units with health units. Each rural centre should be responsible for the following :—

(1) Vaccination

(2) Registration of births and deaths

(3) Conducting educational propaganda

(4) Holding school clinics and giving health instructions in schools.

(5) Generally looking after sanitation of the area, particularly in cases of fairs and festivals,

(6) Protection of sources of water supply.

(7) Enquiring into the plague spots within that area, whence epidemic diseases start every year and providing facilities for observation and investigation in all cases of epidemics.

Peripatetic dispensaries may also aid the work of the village health centres. They would not only give help to the suffering villagers, particularly in times of epidemics, but will also be very powerful agencies for propaganda against diseases such as we need urgently. In Bengal, a scheme of giving relief to the sufferers from Kala Azar and Eye Diseases, with the help of mobile dispensaries, has been in operation for several years with remarkable results. People not only have benefited by the work of the men employed but the consciousness of the people towards the method of prevention of some of these diseases has considerably been aroused.

URBAN CENTRES.

The urban health centres besides performing dates similar to the rural centres should be particularly concerned with the health problems of factory labour and workers in mines, shipping, railway and aerial transport, with supervision of food and drugs, poisonous or otherwise, and with health in jails.

SERVICE FOR EPIDEMICS.

Besides these rural and urban centres, there should be, to my mind, a special staff trained to work for the control of epidemics. Epidemics means mass infection. On a reference to a mortality table it will be seen that preventable diseases like Malarial Fever, Plague, Small Pox, Cholera, Dysentery, Tuberculosis, Ankylostomiasis, Rabies, Leprosy, Kala Azar constitute 66 per cent. of the total deaths in the year. The incidence of these diseases is also correspondingly high. The treatment of cases of malaria and cholera and, to a certain extent, of plague has become more or less stereotyped. We know that in these diseases, prevention is better than cure. We also know the seasonal incidence of some of these diseases for each area. It is asserted that an epidemic starts almost invariably from one particular centre in a district and then spread to neighbouring areas. If we can, adopt early and effective measures, as soon as the first case appears in an area, we may prevent the disease spreading and the need for providing treatment of a large number of such cases will not arise. Hence my suggestion is to have an epidemic staff as a part of health service, trained to treat particular diseases, who will be stationed at different convenient centres. Fortunately, the seasonal prevalence of most of these diseases does not coincide, so the same staff can in many cases deal with several types of epidemics. It would be the duty of the epidemic staff to be ready for emergency summons at any moment

like the fire brigade officers, and at the earliest opportunity proceed in a body to the seat of origin of the epidemic and try to exterminate it.

MEDICAL RELIEF SERVICES.

If we are able to stop the spread of epidemic diseases, which cause the largest number of morbidity and mortality in India, we are left with a comparatively smaller problem, namely, that of provision of treatment of about 10 to 15 millions of people for the whole of India, suffering from diseases other than those dealt with by the epidemic staff as mentioned above. A small proportion of this number would be treated in the existing hospitals and dispensaries. But what about the remainder ? How to meet the huge problem of finding medical relief for such a large number who reside mostly in rural areas and are to-day practically without any suitable or adequate medical treatment ? There are three alternative courses which can be suggested to meet this situation. It is a fact that it is difficult to get trained doctors to go and practice in village areas. They do not find it paying enough to go there, there are no social amenities, the sanitation is very poor, and they have to remain near a town to get the best return for their labour. The first suggestion is, therefore, to create an inferior grade of medical men who will spend a period of three years in a school, just to learn the elementary principles of scientific medicine and will then be sent out to the rural areas to supply the medical needs of the people. I do not think this suggestion at all helpful and I believe it to be a retrograde step Even to-day every village area has got quacks, inadequately trained persons or charlatans who treat patients. As I have said above, no person who has obtained less than five years' training can practise scientific medicine. And it is this type of person that villagers want. It is not that they do not now get any treatment, but to day they know enough of their illness to understand the value of scientific medicine. On the other hand, the village practitioner, when in a dilemma, would like to have the advice of a trained physician. Often a patient in the village may be unwilling or unable to journey down to a city and obtain scientific medical aid. Therefore, I say, the creation of a new type of village practitioners by giving them a three years' training would not meet the situation.

The second suggestion is to devise a scheme whereby it would be worthwhile for a scientifically trained doctor to go to a village area I admit that it is not very easy to suggest a complete scheme for all parts of India. During the last decade, in the Punjab and the Madras Presidency, a scheme has been followed, namely, that of 'subsidising' private practitioners intending to practise in rural areas. A dispensary is opened in a village. A private practitioner is placed in charge of the dispensary and is given Rs 25/ per month by way of subsidy. Such a practitioner is not liable to be transferred to another dispensary without his consent, but in other respects he is subject to the same conditions of service as the whole time medical officers in charge of rural dispensaries. A grant of Rs. 500/- per year is given for drugs and instruments and the total cost of up-keep of such dispensary is about Rs. 1,000/- or Rs. 1,100/- a year. The doctor is entitled to charge for medici-

nes supplied to the patients except to the very poor, in accordance with the scale which lays down a maximum chargeable in this manner. To my mind this scheme requires further development and each province of India may modify it to suit local needs but the objective of such a scheme should be, (1) to do away ultimately with the present type of medical services and replace it by independent medical practitioners, who will be helped in the earlier stages of their carrer, by contributions, capital or recurring, from the State, and (2) to develop a sort of panel system, whereby the State subsidy, which often represents in direct contribution by the people, may be re placed by direct contribution from the patients. This will restore the individualistic traditions of medical practice and will improve the relationship between the patient and his doctor. At present an ordinary rural dispensary costs the Government or the District Board about Rs 2,500/- a year, so the expenses to the State on the present that "Rural Dispensary" system are two and half times as much as on the "subsidy" system. In justification of the subsidy system, therefore, it may be said that it is cheaper to maintain a centre of this type when the cost is borne partly by the State and partly by direct contributions, however small, from the patients themselves. This system makes the patients feel that they have not to accept charity; it increases their sense of self-respect and it also removes the "service" mentality from the mind of the medical practitioner. This system also brings the patient in close and direct touch with the doctor Each such village practitioner, so subsidised, will be encouraged to develop a "voluntary" system of insurance which would form the nucleus of the "compulsory" insurance system which is now in operation practically in every country in the world.

Sickness and Unemployment Insurance.

From what I have said above it is clear that our problem is vast. It is not easy to devise a scheme of giving efficient medical relief to millions of patients living in villages isolated from one another, with means of communication between them difficult and in certain periods of the year absent. The marshy deltaic districts of Bengal, the dry parched area in the North, the unfavourable weather conditions in India, the polluted sources of drinking water, are physical factors which enhance our difficulties. There are 500,000 villages in India, of which 425,000 have population of less than a thousand. Therefore, poor as they are, the villagers cannot afford to maintain a doctor in a village or even in a group of villages and any form of concerted action amongst them to establish a "voluntary" system of insurance against sickness and unemployment is out of the question.

Let us look to the other side of the picture. With the increasing poverty in the land, the starving poor is becoming more and more a victim of diseases which are and have been found to be preventable in other countries and lands. And yet the poor by themselves cannot arrange for proper treatment in case of illness. The tragedy lies in the fact that while poverty in this country is increasing, medical practice is getting more and more expensive.

There are many reasons for it. Improvement in training and progress in science, forces the medical students now to invest more money in education and equipment than has hitherto been found necessary; even within the last two decades such investment has increased by hundred per cent, if not more. On the other hand, with the increasing knowledge and progress in medical science, there is a greater tendency to specialise, and specialisation means greater cost. Even a patient promotes a tendency to such specialisation. The more learned he becomes in medical matters, the more is he likely to attempt diagnosis of his own case and the more will he have the tendency to run to specialists. The latter may find it necessary to send the patient to another specialist, and so on, with the result that the more efficient a physician becomes, the more costly becomes his services. But this is not all. The profession is caught in the current of times. The young doctor, who went into debts in order to pay for efficient training and equipment, sees round him businessmen who acquire wealth and status and sets up a high standard of living. The physician feels that he has worked harder and sacrificed more than the businessmen. Why should he not have as much return as they? To the city, migrates the businessman; to it also goes the young doctor; both of them anxious to earn his utmost. While the medical service have admittedly become more costly, the lay public have recognised the dramatic advances that have been made in medicine, and, therefore, they are anxious to secure the services of medical experts, although they are not able to pay for the same. The question arises, therefore, is society in general, and the medical profession in particular, in a position to meet this growing demand? In educated minds, an argument such as the following suggests itself: "Medical science can now prevent or cure certain major diseases. Many people continue to suffer from such diseases. Ergo, medical science does not serve the people as it should." The more people long for medical aid, the less can they afford to have it This is a serious impasse in the relation of the public to the profession. It is natural that we should try to find out some method of solving this problem In the West, during the last two centuries, various guild funds or benefit organisations have developed, the basis of which is, that those who cannot afford to pay the heavy expenses of medical aid in serious illness, can meet these costs if they are spread over years by premium payments. Gradually various types of insurances developed in these western countries. Before going to discuss these various types, I should draw your attention to the fact that it is conceded that there are some obvious disadvantages in this system of insurance against sickness. It has been argued that this system might lead to malingering. It is also said that this system would lead to dimunition of substantial reward to the medical practitioner for his services and would naturally tend to decrease the physician's personal interest in insurance cases After all, doctor is only human, and it is just likely that he would pay careful attention to those who pay well in the course of private practice and treat somewhat indifferently the insurance patients for whom only small fees are paid in a routine manner. But the most serious criticism of a system of this type is that it does away with the individualistic tradition in medicine. The patient loses the personal touch of the doctor and the whole profession be-

comes a sort of business. On the other hand, the great advance of this system lies in the fact that those who are weakest economically, can avail of medical aid, no matter what their station in life is, without being "charity" cases. Such a co-operative system would provide aid during illness as it provides mass education for the poor. Remembering the difficulties of the medical practitioner towards getting a decent sum for their living, as also the fact that the large bulk of people in all countries cannot afford to pay for medical services in these days, the League of Nations at Geneva adopted a Draft Convention in 1927, recommending to the Governments of all the different nations, a system of health or sickness insurance. This system, the Conference of the League urged, should be operated by self-governing societies under the administrative and financial supervision of competent public authorities and in consultation with medical experts. They should not be carried on for profit. In case no such society existed, the Governments were urged to provide a State system. Every country in the West to-day has adopted some system or other of national insurance. They argue that it is as important to save the life of its citizens as it is to protect forests and preserve the animals in them. Admittedly, reduction of mortality means conservation of national wealth. In America, before introducing the scheme of Insurance, a committee of One Hundred was appointed by the President to report on "National vitality, its wastes and conservation." Prof. Fisher of the Yale University who drew up the Report of the Committee declared it "to be both bad policy and bad economy for the State to leave protection against disease either to the weak and spasmodic efforts of charity or to the philanthropy of physicians." In India, no other system exists except doling out charity to the suffering poor. We have the different services, and there are the hospitals. From what I have said above, it is clear that the services and the Hospitals alone cannot solve the problem. The recommendation of the League of Nations for formulating health Insurance schemes came to India. The Royal Commission on Labour discussed certain aspects of the question and submitted its report in 1931. I am indebted to my friend Dr. Chaube of Delhi for the supply of information on the question.

The Report of the Royal Commission says "By common consent, the incidence of sickness is substantially higher in India than in western countries. Medical facilities are much less adequate, and the wages generally paid, make it impossible for most workers to get through more than a very short period of illness without borrowing." In another part, it states: "The question of making provision for them during sickness, even if it had not been raised by the Government, would have been forced on us by what we found in every industrial centre." The Provincial Governments in India all argued that it was not possible to introduce such schemes now. The Labour Commission, therefore, naturally concluded that it was impossible to introduce the system in India, particularly as there was no reliable statistics as to the incidence of sickness amongst workers, nor any estimate as to the cost involved, of any benefit that is desired to provide. The Labour Commissioners, therefore, suggested the formation of a Committee for collecting

statistics in order to come to a decision. Meanwhile, the Commissioners suggest the formation of a central non-contributory medical aid society, whose funds would be provided by the employers and the employees, and from which medical aid would be given to the workers. In other words, the Government would not do anything, leaving the workers and the sufferers to help themselves.

While every country in Europe and America has adopted some form of compulsory sickness insurance to protect the poor people against disease and unemployment, India still lags behind Even a type of agricultural insurance has been introduced in Great Britain, Germany, Irish Free State, Norway, Poland, Bulgaria, Austria and Russia. Ordinarily, there are three types of insurance met with in these countries. Firstly, there are the voluntary institutions, depending on the help they receive from various social and religious associations. These institutions are of no use for the general masses in India. Secondly, there are the Company insurances which have a limited scope, because they are applicable only for those cases where the insured are able to pay sufficiently to the Companies for them to make profits in the transaction. Lastly, comes the compulsory form of health insurance. The principle behind this system is that a sick person is always a burden to the rest of the members of the community, and, therefore, he should be forced to join some form of insurance scheme by which he gets relief in cases of illness. It is recognised that this form of insurance is most easily worked out among industrial workers. But as I have mentioned above, this system has been in vogue among agricultural population also in many countries. The employers and the employees would each make their own contributions towards this scheme and the State will do the rest. The employer pays because a healthy and contented employee is an asset to him. The employee pays because he gets back a portion of what he pays, in the way of medical treatment and he virtually pays for such medical treatment on a deferred basis. In those cases where the people are not able to pay at all, because they are not wage earners, the State must make necessary contributions for them.

No one at this stage, without further information, can lay down any scheme which is suitable for India, nor can one assert that any particular system would be suitable for all parts of India But I desire to emphasise that some step must be taken immediately to prevent this great waste in men and money. Therefore, I suggest that the Central Government should take early steps to appoint a Committee to inquire into the whole problem. They must not stand on ceremonies and consider their own experts as infallible guides in such matters. Failing the Central Government, the Provincial Governments should take necessary steps as early as possible. The question remains as to what part the medical profession in India is going to take in this matter. In England, the British Medical Association has given constructive suggestions at every stage of the introduction of health insurance scheme in that country, and I see no reason why the members of this Association, individually and collectively, should not give all possible help towards the solution of this great problem. I do not conceal the fact that there are

difficulties in the way of introducing any form of health insurance in India. Those who are in the Service to-day, and who, in the eyes of the people outside India, materially count, would object to any step being taken towards this end which might jeopardise their interests. Any scheme which proposes to bring the private medical practitioners into the National Organisation of State Medicine would be opposed by those who have now got the monopoly of position in the State. The solution of the problem is thus beset with difficulties but with determination and perseverance it would not be difficult to find a solution. Friends, let us band together and help to make this dear Country of ours a land of health and affluence and to rehabilitate it in its pristine glory.

THE PRIVATE MEDICAL PRACTITIONER AND THE PUBLIC HEALTH DEPARTMENT.

The two branches of Health, the curative and the preventive, are not things apart; the division is only artificial. They are inseparably joined in an essential unity. The conscientious work of the general practitioner among the masses is really an important part of preventive medicine and of public value.

A private medical practitioner who treats his patients conscientiously and thoroughly performs most valuable public health work. He aims not only to cure his patients but to keep them in health. He sees illness in its early stages and prevents the mild disorder from becoming a serious and complicated disease.

The very day he becomes a resident medical practitioner, he has, whether he likes it or not, a number of public responsibilities thrown upon him. He is responsible for certifying the cause of death and for notifying infectious diseases and a number of duties under various Municipal Acts. The numerous and various certificates to which a private medical practitioner subscribes his name are all legal documents. The Food and Drug Act, The Health Act, The Education Act, The Workmen's Compensation Act and numerous other ordinances bring the Private Practitioner actually into the sphere of public health work. It is incumbent upon him not only to treat his patients to the best of his abilities but also actively to co-operate with the Health Authorities in trying to prevent the spread of the illness to other people. In the household he would indicate to the people the nature of trouble and the means to be adopted to protect others against infections, *e. g.*, in Typhoid fever, the medical man (practitioner) stresses the need for care in the disposal of the excreta and in the handling of the patient. In Diphtheria, he calls for swab examination not only of the patient but of others in the household and explains the danger of infection. By his attention to these matters, the medical man is assisting the work of the Health Department and impresses on the people of the household the necessity of the work of the local health authority, in their own interest. The preventive aspect is important and in this sphere, the practitioner is doing valuable spade-work.

In sanitation, the Medical Practitioner has little direct function but often, he can, in the course of his daily work, be of great assistance to the Health Department. When he observes insanitary condition in the premises of his patients, he should point out to them their failure to observe proper hygienic requirements. When he advises his patients on matters of drink and food, the practitioner is doing useful public health work. Wise advice is eagerly sought and invariably attended to

On the Continent, the services of private practitioners are well recognised; so much so, that the Health Departments employ medical practitioners in a part-time capacity as their officers of health. Their duty is to advise the local boards on public health matters. Thus, opportunity is given to the medical practitioner to influence and to mould the public health work of the State.

The big scientific advance in medicine renders the development inevitable and the spheres of influence of health departments have since widened.

Medical treatment is not merely a matter of looking at the tongue, feeling the pulse and then writing a prescription. It is rather a matter of carefully investigating the patients' symptoms, making a thorough examination of his physical and mental conditions and advising special examinations, wherever necessary, such as X-ray, Bio Chemical and laboratory. The last one which has developed since, by leaps and bounds, aids, if not, leads to the correct diagnosis—the basis for sound treatment. It is one of the major medical problems of the present day to ascertain the sphere of the private physician in the field of public health.

Conditions in India seem to be otherwise. The Government have yet to realize the most important public health work the private practitioner is doing every day in his practice. Time has now arrived when a large number of private medical practitioners could be employed on Honorary basis in Public Health work. Mention has already been made by the Ministry of Health in Madras, of the need for such co-operation.

Public Health work could be made easy if such co-operation from medical practitioners is encouraged by affording laboratory facilities to them in order to arrive at correct diagnosis of cases which is the basis of successful treatment.

" The time is not far distant when the health services will in large measure be staffed by general practitioners on a part-time basis, working scheduled hours. It is useless to expect doctors to take an interest in medical services in which they cannot take a responsible share."

The Government Communique regarding the subjects discussed at the Health Ministers' Conference, held at Madras recently, seems to be very hopeful. By the private practitioners having free laboratory facilities in diagnosing infectious diseases, a bright future could be envisaged for successfully combating epidemics and other dangerous diseases like Tuberculosis.

U. D. GOPAL RAO,

Thambu Chetty Street, Madras.

JOURNAL OF SOUTH INDIAN MEDICINE

JANUARY, 1938.

OURSELVES.

We are pleased to have this opportunity once again to greet the members of the Union and the readers of this Journal and to congratulate them on the success of the year that is past. We wish them an equally successful and useful year.

Our readers are well aware of the difficulties that we had to contend with during the early part of the year that is gone. We have got over those difficulties. The Journal is being issued regularly, and there are signs that it is increasingly read. The number of letters that the office receives from our readers in the mofussil shows the increasing interest of the profession in the Journal and the activities of the Union. The profession will be glad to know that the circulation of the Journal is increasing. The membership of the Union has increased by 100 per cent during the last six months and if the application for membership which we receive almost daily is any indication at all it is certain that the membership will steadily advance. The finance of the Union is satisfactory.

The Union owes much to the enthusiasm of its governing Council and the business-like way in which the various members tackled the different problems of the Union. The newly constituted Editorial Board and its energetic secretary are now getting into the stride and the profession may therefore anticipate better service in the near future. With the new volume which begins next April, the Journal is likely to have more instructive and arresting features. But no venture can hope to continue to thrive unless all those who are concerned take a live interest in it. The South Indian Medical Union and its Journal are not concerned with the members only. They belong to the Medical profession of South India. We therefore appeal to the members of the profession in this part of the country to do all they can to advance the interests of the Union and the Journal.

With this appeal we wish the members of the profession of South India a Happy and Prosperous Year.

THE XIVTH ALL-INDIA MEDICAL CONFERENCE

The Conference which met towards the end of last December was the first of its kind to be held in Madras. It was a unique occasion and we are proud to feel that the medical profession and the Government of this province have whole heartedly co-operated to make the Conference the great success that it was. We are told that this session attracted the largest number of delegates from all over India, and many of India's foremost medical men were present at the Conference. All the meetings were well attended, and medical men took a very keen interest in the scientific sessions as well as in the medico-political gatherings. Those of us who have attended the first All-India Obstetric and Gynaecological Congress held in Madras two years ago, and in the previous year the Madras session of the All-India ophthalmological Conference fully anticipated the success of the All-India Medical Conference.

These conferences provide opportunity for the medical men of various provinces to meet each other that they may exchange views on the many problems of medical relief, medical progress and scientific advance. Even more, such meetings enable the various provinces to understand each other better, to recognize their difficulties and appreciate their achievements.

All the addresses delivered at the opening session of the conference are able and comprehensive. In his opening address the Hon'ble Dr. Rajan emphasized the need for a central All India Medical Organization which could speak for the medical profession of this country in its dealings with other countries. His address contains many ideas on various aspects of the medical profession and medical relief of this country. In the limited time and the short compass of an opening address he had obviously to compress his thought. We hope that with more time and leisure he will expand his views so that all could catch their spirit. The address of Lt. Col. Pandalai, the Chairman of the Reception Committee was clear and forceful. But some among those that were present feel that he need not have emphasized as much as he did the defects of the Indian Medical Service. We appreciate his attitude. It requires rare courage to criticize adversely the class to which one belongs. But there are occasions when its display may lack grace.

Anyway this does not concern the practitioners. It may be a cause of argument between himself and the service to which he still belongs. We are therefore very pleased to know that he is enthusiastic about the honorary scheme in this province. There was a time when the profession was not sure of his attitude, especially since the time when two honorary assistant surgeons of the hospital of which he was superintendent were treated shabbily by the authorities. Therefore this public confession of his faith should go a great way to reassure them.

The presidential address of Dr. B. C. Roy is very long and deals comprehensively with many of the problems which agitate the mind of the profession and the public. A considerable portion of the address is devoted to the subject of the Medical Council of India and the reorganisation of the medical services and medical relief. Dr. Roy is one of the influential members of the Medical Council of India and when he talks of the defects of the council, he should be understood to be speaking with inside knowledge and authority. Even so, we find it difficult to agree with him in his arguments for the unified control of standards of medical education. We understand that this council is constituted to see to the maintenance of a particular level of basic standard in medical education. It cannot recognize anything less than that and hence there is no question of its controlling such standards. In fact, Dr. Roy himself realises this in a later portion of his address where he yearns for a satisfactory standard in medical education. What is therefore needed is the education of the various provincial Governments to realize that higher standards of education is necessary to obtain medical men who could be considered to be satisfactorily equipped to deal with the modern developments of medicine. We do not pretend to review the address of the President exhaustively in this issue. We hope to refer to this address in a subsequent issue.

G. O. No. 3600 P. H., dated 23—12—1937.

We draw the attention of our readers to the proceedings of the Council of the South Indian Medical Union published on page LX of this issue. The council considered the new G. O. as regards the extension of the Honorary System. The Council carefully considered the new rules and has recorded its findings as published in this issue. We are submitting a Memorandum to the Government on the lines indicated in the proceedings. We hope to publish the full text of the Memorandum in the next issue.

CORRESPONDENCE.

BOMBAY PRIMARY F. R. C. S. EXAMINATION. ITS LESSONS.

SIR,

All the 24 candidates from Madras, who appeared for the primary F. R. C. S. examination in Anatomy and Physiology in January 1938, have failed. Madras which distinguished itself in the previous Madras and Calcutta Examinations, is knocked on the head. I cannot believe, that Madras has so suddenly deteriorated, as to deserve this treatment. There is something wrong somewhere, and knowing the merits of the students, with whom I had close and recent contact, I know the students are equal to any others in India, England, Egypt and other Dominions.

What are its lessons? Why depend on this examination for producing our future surgeons? More bodies are available in India for anatomical studies. The clinical material is abundant and the clinical soil can produce master surgeons. As self-respecting men, the time is ready for the evolution of a self-sufficient system of post-graduate medical education. Except in exceptional instances, none of our graduates should hanker after foreign diplomas. Even for medical appointments in India, our own higher degrees and diplomas should be given preference to the foreign ones. We should, at any rate, in Madras, have nothing to do with the future primary F. R. C. S. Examinations.

E. S. G.

DRUGS AND APPLIANCES.

The French Medicines agency has supplied quantities of the drug Crinosthenyl and Crinomenstryl for clinical trial. The reports from the practitioners who have used the drugs under reasonably controlled conditions are encouraging. It is the general opinion that Crinosthenyl is useful in cases of neurasthènia and Crinomenstryl in the vague distempers of the climacteric. These drugs are as useful as some of the more expensive endocrine products.

ASSOCIATION NOTES.

SOUTH INDIAN MEDICAL UNION.

Minutes of the meeting of the Council of the Union held on Monday the 20th December 1937 at 6 p. m. at 32, Broadway, Madras.

The following members were present.—

Dr. M. Subramania Iyer.
,, T. Satakopan.
,, M. Krishnamoorthy.
,, V. C. Sudarsanam.
,, P. Rama Rao.

Dr. M. Subramania Iyer was in the chair.

1. The Financial Statements for the months of October and November 1937 were presented and approved.

2. The following practitioners were enrolled as members of the Union.

1. Dr. N. K. Sampath, M B., B.S , Coimbatore.
2. ,, P. Vadamalayan, M.B., B.S , Madura.
3. ,, R. Lakshmanan, M B., B.S., Vellore.
4. ,, E Ramalingam, B A , M.B., B.S., Vellore,
5. ,, A R. Rangaswami, M.B., B.S , Arni.
6. ,, C. K. Dharmarajan, M.B., B.S., Arni.
7. ,, N. Srinivasan, M.B., B.S., D.L.O., Madras
8. ,, G. Dorai Raj, M.B., B.S., Koilpatti.
9. ,, C. Radhakrishnan, L. M. & S. Madras.
10. ,, P. S. N. Sarma, L M.P., Bhimavaram.
11. ,, Miss. D. E. Julian, L.M.P., Ambur.

12. Dr. C. Raghavendra Rao, L.M.P., Adoni.
13. „ K. Srinivasan, L.M.P., Vellore.
14. „ P. Gurumurthy L.M P., Rajahmundry.

With a vote of thanks to the chair the meeting terminated.

Minutes of the meeting of the Council of the Union held on Monday the 3rd January 1938 at 6 p.m, at 32, Broadway, Madras.

The following members were present.—

1. Dr. M. Subramania Iyer.
2. „ V. D. Nimbkar.
3. „ T. Satakopan.
4. „ G Zachariah.
5. „ M. Krishnamurthi.
6. „ P. Govinda Rao.
7. „ S. Thambiah.

Dr. M. Subramania Iyer was in the Chair.

1. The following practitioners were enrolled as members of the Union.

1. Dr. A. R. Viswanathan, L.M. & S. (Hyd) Madras.
2. „ C. S. Gurusawmy, L.M.P., Madras.
3. „ A. V. Seshaiah, L.M.P., Singaroyakonda-Nellore.

2. The Council then proceeded to consider the Scheme for medical relief recently published in the papers.

The following were the findings of the Council.

The new G O. has generally accepted the recommendations of the last Honorary Committee. The above Committee was unanimous in its recommendation.

(*a*) that Honorary Medical Officers should be appointed to be in full charge of Dispensaries and small hospitals.

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(*b*) that Honorary Medical Officers should be eligible for Professorship and Lecturership in the Schools and Colleges.

(*c*) that Honorary Medical Officers should replace paid Medical Officers as vacancies occur, and

(*d*) that there should be a greater increase in appointments of Honorary Medical Officers.

The Council considers that by accepting these recommendations and agreeing to put them into action immediately the Government has taken the Honorary Scheme many steps forward. It is hoped that exigencies of service and other conditions would not be allowed to postpone the working of the scheme very long.

The Council then considered the new recommendations in the same G. O. First of all the classification of the Honorary Officers. It is not obvious in the published rules whether the present House Surgeon and House Physician are also covered by the term Honorary House Surgeon and Physician mentioned in the G. O. The Council believes that new graduates and licentiates who work as interns in hospitals soon after the graduation should be treated apart as at present.

3. *Payment of Honorarium.*—The Council takes exception to the statement of the Hon. Minister at a public function that Rs. 20/- a month is a living wage; secondly the principle of allowances is wrong; and therefore no allowances should be given to Honorary Officers. But if the Government still think that they should pay the allowances to the Honorary Medical Officer, there should be no option given to the individual members to refuse the allowance. For such a measure will bring into existence a undesirable feeling among some of the members of fictitious superiority. If allowances is to be given the Juniors should get more, the Seniors need not be paid any allowance except for academic teaching work. The Union would respectfully suggest the allowances should be given to the Honorary Assistant Medical Officers for the first 5 years as follows. Rs. 75/- per month for the first 2 years and Rs. 50/- per month for the next 3 years. After which no allowances should be given.

4. *Tenure of Five Years.*—Wrong in principle. The chief object of young men joining Honorary appointments is their ambition to chalk out carriers for themselves. If the young doctor knows that he is to be pulled up at the end of every 5 years, there will be no incentive to voluntary service.

It is true in the present state of the country and the deplorable condition of the profession, a large number of practising doctors may be obtained to man the hospitals and dispensaries on conditions laid down by the Government however irksome and unfair such conditions might be. But the Union respectfully suggest that a much higher state of appreciation is expected of responsible Government.

The next objection to this system of tenure is more urgent. Many people would be tempted according to this scheme to settle down in the District Headquarters and Taluk Headquarters as well as other areas in the country. If there is always the possibility that at the end of 5 years these people will be turned out of the hospitals and another set of men encouraged to take over the work in the hospitals, the practitioners who settled in the district and other places will hardly get a sporting chance to build up a living for themselves, and in spite of this if people go and settle in these places it is impossible for them to be enthusiastic in their services to the institutions concerned. Thirdly, if the object of the tenure is merely to give opportunity for larger number of men to get the benefit of the hospital training the Union believes that for a number of years to come there will be room practically for all medical men who are in a position to work in hospitals to be so employed. Again without long tenure it would be impossible to obtain Honorary officers capable of taking up places as Professors and Teachers.

The idea of tenure and possible re-employment tends to place the Honorary officers under the absolute mercy of the D. M.Os, since the latter's opinion is likely to tell most when re employment is under consideration.

5. *Period of Duty in the Institutions.*—It is mentioned that H. M. Os should spend at least 3 hours of the best part of the day in the hospitals. Such hard and fast instructions are unnecessary The time required to be spent depends on the amount of work, the number of beds and nature of the cases at the time. In some places there may be hardly work for an hour ; on other occasions the Medical officer may have to spend 3 hours or even more. In the absence of side rooms, laboratories etc., it is impossible to spend 3 hours usefully in the wards on many occasions. Duties in teaching hospitals and other institutions differ.

A proviso that H. M. O. should be in the hospital sufficiently long to complete the work would be enough.

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6. *Hospitalization of private Patients.*—If it is the idea of the Government that patients who have been seen by the Medical officers outside should not be admitted into the wards under their care, the Government should say so and make the rule absolute and applicable to all Medical officers of the institution. Really it will not be possible to make a rule like that in case of Government servants who might have been seen by the Government Doctors. Why should the rule apply only to the H. M. Os ?

The H. M. O. may not be responsible at all for the admission of the patient into the hospital. A patient sees the M. O. outside. He is advised hospitalization and sometimes a note is given to the effect that the case requires hospitalization. The patient may find his way into the particular doctor's wards without any help from the latter. Still one may say that the patient was indirectly admitted by the H. M. O.

This rule is practically impossible to work in the case of Honorary Medical Officers who are in charge of Special Departments. By virtue of his being the only person to deal with such cases patient whom he recommends should be admitted in the hospital will naturally be admitted under his care. If the Government is desirous of putting down the abuse of hospital privileges in the matter of admission of patients, we suggest that the most useful plan would be to appoint capable and responsible officers to scrutinize the social status and income of the patients who seek admission into the hospital. If this scrutiny is carefully done a good deal of abuse is likely to be prevented.

After a vote of thanks to the Chair the meeting was adjourned for further consideration.

ALL-INDIA MEDICAL LICENTIATES' ASSOCIATION

The Annual General Body Meeting of the All-India Medical Licentiates' Association, Madras branch, was held on Thursday, the 23rd December 1937, at 57 Thambu Chetty Street, under the presidency of Dr. R. Ramanujulu Naidu.

The Annual Report for the year 1937 was read and passed unanimously.

The forward policy and the leading steps taken by the Madras Government to establish a uniform standard of minimum Medical qualification in the Presidency and the congratulatory resolutions regarding the achievements of Hon'ble Dr. U. Rama Rao as President of the Madras Legislative Council, Hon'ble Dr. T. S. S. Rajan as Minister of Public Health, Madras, and Dr. P. S. Srinivasan of Conjeevaram, as a member of the

Madras Legislative Council, and also the establishment of a common register as outlined by the Parliamentary Committee of the Association, formed some of the important items in the report.

The following office-bearers were elected for the new year:
Patron.—Hon'ble Dr. U. Rama Rao.
President.—Dr. Ramanujulu Naidu.

Vice-Presidents.—Drs K. S. Sivaramakrishna Iyer, K. B. Bhujanga Row, U. L. Narayana Rao.

Secretaries.—Drs. U. D. Gopal Rao, G J. Narayanaswami Naidu.

Managing Committee.—Drs. T. V. Ranganatha Rao, Y. Suryanarayana Rao, G. Subbarayudu, A. Viswanathan, M. V. Suryaprakasa Rao, T. R. V. Iyer, K. Rama Rao, M. Kannan, M. V. Hanumantha Rao, K. Venkat Rao.

Dr. D. V. Venkappa was unanimously proposed as the Provincial Secretary, Madras and was also thanked for having enlisted members to the Association in the City as well as in the moffussil.

The following doctors, K. B. Bhujanga Rao, G. Subbarayadu and Y. Suryanarayana Rao, were elected as delegates to the ensuing Conference of the Association.

Appreciative references were made to the Editor, Indian Medical Journal for conducting it regularly to the satisfaction of all the members.

The meeting terminated with a vote of thanks proposed by Dr. K. S. Sivaramakrishna Iyer to the out-going office-bearers and the members present.

NOTICE.

MADRAS MEDICAL COUNCIL.

All those who possess the qualification 'Licentiate of the College of Physicians and Surgeons of India' or any other qualification registered in the past on the Madras Medical Register, may apply to the Registrar, Madras Medical Council for registration within one year from the date of this notification.

The application should not, however, be accompanied by the fee for registration, which should be remitted to the Registrar of the Council, only after receipt of instructions from him.

(By order of the Madras Medical Council)

P. KRISHNA RAO,
Ag. Registrar, Madras Medical Council.